Annual Hospital Questionnaire Parts A-C for 1/1/2006-12/31/2006

UID:

Part A: General Information

Georgia Department of Community Health

1. Identification: **Due Date: February 29, 2008** **Year:**

Facility UID					
a. Facility Name		b. County			
c. Street Address		d. City		e. Street Zip	
f. Mail Address		g. City		h. Mail Zip	
i. Medicaid Provider Number		j. Medicare Provider Number			

2. Report Period:

Report data for the full 12-month period, January 1, 2006 through December 31, 2006 (365 days). Do not use a different report period.

Check the box to the right if your facility was not operational for the entire year ☐

If your facility was not operational for the entire year , provide the dates the facility was operational below:

Part B: Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey:

Name Title

Telephone: Fax E-mail

Part C: Ownership, Programs, and Licensure

1. OWNERSHIP, OPERATION AND MANAGEMENT as of the last day of the Report Period, indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the Organization Type. If the category is not applicable, the form requires you only to indicate "Not Applicable" in the Legal Name column. You must enter some response in each category.

Category	Full Legal Name (or "Not Applicable")	Organization Type	Effective Date
a. Facility Owner:			
b. Owner's Parent Org:			
c. Facility Operator:			
d. Operator's Parent Org:			
e. Mgmt. Contractor:			
f. Mgmt's Parent Org:			

2. Check the box to the right if there were any changes in the ownership, operation, or management of the facility during the report period or since the last day of the Report Period. ☐

If checked, please explain in the box below and include effective dates.

Part C: Ownership, Programs, and Licensure (continued)

If item 3, 4, 5, 6, or 7 is checked, provide the name and location of the organization.

3. Check the box to the right if your facility is part of a health care system. ☐

   Name _____

   City _____ State _____

4. Check the box to the right if your hospital is a division or subsidiary of a holding company. ☐

   Name _____

   City _____ State _____

5. Check the box to the right if the hospital itself operates subsidiary corporations. ☐

   Name _____

   City _____ State _____

6. Check the box to the right if your hospital is a member of an alliance. ☐

   Name _____

   City _____ State _____

7. Check the box to the right if your hospital is a participant in a health care network. ☐

   Name _____

   City _____ State _____

8. Check the box to the right if the hospital has a policy or policies and a peer review process related to medical errors. ☐

9. Check the box to the right if the hospital owns or operates a primary care physician group practice. ☐

10. **Managed Care Information:**

    a. Does the hospital have a formal written contract that specifies the obligations of each party with each of the following? (check the appropriate boxes)

       1. Health Maintenance Organization (HMO) ☐
       2. Preferred Provider Organization (PPO) ☐
       3. Physician Hospital Organization (PHO) ☐
       4. Provider Service Organization (PSO) ☐
       5. Other Managed Care or Prepaid Plan ☐

Part C: Ownership, Programs, and Licensure (continued)

b. Check the appropriate boxes to indicate if any of the following insurance products have been developed by the hospital, health care system, network, or as a joint venture with an insurer:

Type of Insurance Product	Hospital	Health Care System	Network	Joint Venture With Insurer
1. Health Maintenance Organization	☐	☐	☐	☐
2. Preferred Provider Organization	☐	☐	☐	☐
3. Indemnity Fee-for-Service Plan	☐	☐	☐	☐
4. Another Insurance Product Not Listed Above	☐	☐	☐	☐

Annual Hospital Questionnaire Part D for 1/1/2006-12/31/2006

UID:

Facility UID

Facility Name

Georgia Department of Community Health

Year:

Part D: Inpatient Services

1. UTILIZATION OF BEDS AS SET UP AND STAFFED (SUS): Please indicate the following information. Do not include newborn and neonatal services. Do not include long-term care units if not licensed as hospital beds. If your facility is approved for LTCH beds report them below .

		SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
a.	**Obstetrics (no GYN, include LDRP)**					
b.	Pediatrics					
c.	Gynecology (No OB)					
d.	General Medicine					
e.	General Surgery					
f.	Medical/Surgical					
g.	Intensive Care					
h.	Psychiatry					
i.	Substance Abuse					
j.	**Physical Rehabilitation**					
k.	Burn Care					
l.	Swing Bed (Include All Utilization)					
m.	**Long Term Care Hospital (LTCH)**					
n.	Other (Specify)					
	Totals					

2. RACE/ETHNICITY: Please report admissions and inpatient days for the hospital by race/ethnicity. Exclude newborn and neonatal.

	American Indian/ Alaska Native	Asian	Black/ African American	Hispanic OR Latino	Hawaiian/ Pacific Island	White	Multi-Racial	Totals
Admissions								
Inpatient Days								

3. GENDER: Please report admissions and inpatient days by gender. Exclude newborn and neonatal.

	Male	Female	Total
Admissions			
Inpatient Days			

Part D: Inpatient Services (continued)

4. **PAYMENT SOURCE:** **Please report admissions and inpatient days by primary payer source. Exclude newborn and neonatal.**

	Medicare	Medicaid	Peachcare	Third-Party	Self-Pay	Other
Admissions						
Inpatient Days						

5. **DISCHARGES TO DEATH: Please report the total number of discharges during the reporting period due to death .**

6. **CHARGES FOR SELECTED SERVICES: Please report the hospital's average charges as of 12-31-2006 (to the nearest whole dollar).**

a. Private Room Rate	
b. Semi-Private Room Rate	
c. Operating Room: Average Charge for the First Hour	
d. Average Total Charge for an Inpatient Day for the Year Ending 12-31-05	

Annual Hospital Questionnaire Parts E-F for 1/1/2006-12/31/2006

UID:

Georgia Department of Community Health

Facility UID

Facility Name

Part E: Emergency Department and Outpatient Services

Year:

Note: Report visits to the Emergency Department for emergency cases ONLY. Do not report units of service.

1. Emergency Visits (emergency visits only)
2. Inpatient Admissions to the Hospital from the ER for emergency cases ONLY.
3. Number of beds available in ER as of the last day of the report period.
4. Utilization by specific type of ER bed or room for the report period.

	Beds	Visits
a. Beds dedicated for Trauma		
b. Beds or Rooms dedicated for Psychiatric/Substance Abuse cases		
c. Other Beds (Specify)		

5. Provide the number of Transfers to another institution from the Emergency Department.
6. Provide the number of Outpatient/Clinic/All Other Non-Emergency visits to the hospital.
7. Provide the total number of Observation visits/cases for the entire report period.
8. Number of cases your ED diverted while on Ambulance Diversion for entire report period.
9. Provide the total number of Ambulance Diversion hours for your ED for entire report period.
10. Provide the number of patients who sought care in your ED but who left without or before being treated. Do not include patients who were transferred or cases that were diverted.

Part F: Services and Facilities

1. **Please report services offered onsite and workload totals for in-house and contract services as requested. Please reflect the status of the service during the report period. The number of units should equal the number of machines.**

Site Codes

1 = In-House - Provided by the Hospital
2 = Contract - Provided by a contractor but onsite
3 = Not Applicable

Service Status Codes

1 = On-Going 3 = Discontinued
2 = Newly Initiated 4 = Not Applicable

Service/Facilities	Site Code	Service Status	Report Period Workload Totals	
Podiatric Services			Number of Podiatric Patients	
Renal Dialysis			Number of Dialysis Treatments	
ESWL			Number of ESWL Patients	
			Number of ESWL Procedures	
			Number of ESWL Units	
Bilary Lithotripter			Number of Biliary Lithotripter Procedures	
			Number of Biliary Lithotripter Units	
Kidney Transplants			Number of Kidney Transplants	
Heart Transplants			Number of Heart Transplants	
Other-Organ/TissuesTransplants			Number of Treatments	
Diagnostic X-Ray			Number of Diagnostic X-Ray Procedures	
Computerized Tomography Scanner (CTS)			Number of CTS Units (machines)	
			Number of CTS Procedures	
Radioisotope, Diagnostic			Number of Diagnostic Radioisotope Procedures	
Positron Emission Tomography (PET)			Number of PET Units (machines)	
			Number of PET Procedures	
Radioisotope, Therapeutic			Number of Therapeutic Radioisotope Procedures	
Magnetic Resonance Imaging (MRI)			Number of MRI Units (machines)	
			Number of MRI Procedures	
Chemotherapy			Number of Chemotherapy Treatments	
Respiratory Therapy			Number of Respiratory Therapy Procedures	
Occupational Therapy			Number of Occupational Therapy Treatments	
Physical Therapy			Number of Patient Treatments	
Speech Pathology Therapy			Number of Speech Pathology Patients	
Gamma Ray Knife			Number of Gamma Ray Knife Procedures	
			Number of Gamma Ray Knife Units	
Audiology Services			Number of Audiology Patients	
HIV/AIDS Diagnostic/Treatment Services			Number of HIV/AIDS Diagnostic Procedures	
			Number of HIV/AIDS Patients	
Ambulance Services			Number of Ambulance Trips	
Hospice			Number of Hospice Patients	
Respite Care Services			Number of Respite Care Patients	
Other(Specify)			Number of Treatments, Procedures, or Patients	
			Number of Treatments, Procedures, or Patients	
			Number of Treatments, Procedures, or Patients	

Annual Hospital Questionnaire Part G for 1/1/2006-12/31/2006

UID:

Georgia Department of Community Health

Facility UID

Facility Name

Year:

Part G: Facility Workforce Information

This information is being collected to support Georgia's healthcare workforce planning activities. Please provide information as of 12-31-2006.

1. BUDGETED STAFF

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2006. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2006.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/ Temporary Staff FTEs
Licensed Physicians and Physician's Assistants			
Physicians Assistants Only (not including Licensed Physicians)			
Registered Nurses (RNs-Advanced Practice*)			
Licensed Practical Nurses (LPNs)			
Pharmacists			
Other Health Services Professionals*			
Administration and Support			
All Other Hospital Personnel (not included above)			

*** Include Therapists, Technicians, Allied Health Professionals, and Assistants/Aides**

2. FILLING VACANCIES

Using the drop-down menus, please select the average time needed during the past six months to fill each type of vacant position.

Type of Vacancy	Average Time Needed to Fill Vacancies
Physician's Assistants	
Registered Nurses (RNs-Advanced Practice)	
Licensed Practical Nurses (LPNs)	
Pharmacists	
Other Health Services Professionals	
All Other Hospital Personnel (not included above)	

3. RACE/ETHNICITY OF PHYSICIANS

Please report the number of physicians with admitting privileges by race.

	American Indian/ Alaska Native	Asian	Black/ African American	Hispanic or Latino	Hawaiian/ Pacific Islander	White	Multi-Racial	Total Physicians
Physicians								

Part G: Facility Workforce Information (continued)

4. Please report the number of Active and Associate/Provisional Medical staff for the following specialty categories. Keep in mind that physicians may be counted in more than one specialty. Please indicate whether the specialty group(s) is hospital-based. Also, indicate how many of each medical specialty are enrolled as providers in Georgia Medicaid/PeachCare for Kids and/or the Public Employee Health Benefit Plans (PEHB-State Health Benefit Plan and/or Board of Regents Benefit Plan).

MEDICAL SPECIALTIES	Number of Medical Staff	Check the appropriate boxes below to indicate if any of these medical staff are hospital-based	# Enrolled as Providers in Medicaid/PeachCare and PEHB Plan	
			Medicaid	PEHB
a. General and Family Practice		☐		
b. General Internal Medicine		☐		
c. Pediatricians		☐		
d. Other Medical Specialties		☐		
SURGICAL SPECIALTIES				
e. Obstetrics		☐		
f. Non-OB Physicians Providing OB Services		☐		
g. Gynecology		☐		
h. Ophthalmology Surgery		☐		
i. Orthopedic Surgery		☐		
j. Plastic Surgery		☐		
k. General Surgery		☐		
l. Thoracic Surgery		☐		
m. Other Surgical Specialties		☐		
OTHER SPECIALTIES				
n. Anesthesiology		☐		
o. Dermatology		☐		
p. Emergency Medicine		☐		
q. Nuclear Medicine		☐		
r. Pathology		☐		
s. Psychiatry		☐		
t. Radiology		☐		
u. Other (specify)		☐		
		☐		
		☐		

5. **NON-PHYSICIANS: Please report the number of professionals for the categories below. Exclude any hospital-based staff reported in Part G, Questions 1, 2, 3, and 4 above.**

a. Number of Dentists (include oral surgeons) with Admitting Privileges	
b. Number of Podiatrists Granted Clinical Privileges in the Hospital	
c. Number of Certified Nurse Midwives with Clinical Privileges in the Hospital	
d. Number of all Other Staff Affiliates with Clinical Privileges in the Hospital	
e. Provide the Name of Professions Classified as "Other Staff Affiliates with Clinical Privileges" above.	

Comments and Suggestions

Please enter below any comments and suggestions that you have about this survey.

AHQ Patient Origin

for 1/1/2006-12/31/2006

UID:

Facility UID

Georgia Department of Community Health

Facility Name

Year:

Patient Origin

Please report the county of origin for the inpatient admissions or discharges excluding newborns (except surgical services should include outpatients only).

(Please see the instructions for further information.)

Inpat = inpatient total
Surg = outpatient surgical
OB = obstetric
P18+ = acute psychiatric adult 18 and over
P13-17 = acute psychiatric adolescent 13-17
P0-12 = acute psychiatric children 12 and under
S18+ = substance abuse adult 18 and over
S13-17 = substance abuse adolescent 13-17
E18+ = extended care adult 18 and over
E13-17 = extended care adolescent 13-17
E0-12 = extended care children 0-12
LTCH = Long Term Care Hospital

To delete a row, press Esc to clear data entry errors. Then click in the margin to the left of the county name and press the delete key.

Total Inpat Admissions
Total Surg Patients
Total OB Admissions
Total P18+ Admissions
Total P13-17 Admissions
Total P0-12 Admissions
Total S18+ Admissions
Total S13-17 Admissions
Total E18+ Admissions
Total E13-17 Admissions
Total E0-12 Admissions
Total LTCH Admissions

AHQ Surgical Services Addendum

for 1/1/2006-12/31/2006

UID:

Georgia Department of Community Health

Facility UID

Facility Name

Part A: Surgical Services Utilization

Year:

Please report the Number of Surgery Rooms, (as of the end of the report period). Report only the rooms in CON-Approved Operating Room Suites pursuant to **111-2-2-.40** a **290-9-7-.28** .

1. Surgery Rooms in the OR Suite

	Surgery Rooms			
	Dedicated Inpatient Rooms	**Dedicated Outpatient Rooms**	**Shared Rooms**	**Total Rooms**
General Operating				
Cystoscopy (OR Suite)				
Endoscopy (OR Suite)				
Other				
Total Rooms				

2. Number of Procedures by Type of Room

	Procedures				
	Dedicated Rooms		**Shared Rooms**		**Total Procedures**
	Inpatient	**Outpatient**	**Inpatient**	**Outpatient**	
General Operating					
Cystoscopy (OR Suite)					
Endoscopy (OR Suite)					
Other					
Total Procedures					

3. Number of Patients by Type of Room

	Number of Patients by Type of Room			
	Dedicated Rooms		**Shared Rooms**	
	Total Inpatient	**Total Outpatient**	**Total Inpatient**	**Total Outpatient**
General Operating				
Cystoscopy (OR Suite)				
Endoscopy (OR Suite)				
Other				
Total Patients				

Part B: Ambulatory Patient Race/Ethnicity, Age, Gender, and Payment Source

1. Please report total number of ambulatory patients for both dedicated outpatient and shared room environment

	American Indian/ Alaska Native	Asian	Black African American	Hispanic OR Latino	Pacific Hawaiian Pacific Islander	White	Multi-Racial	Total
Number of Ambulatory Patients								

2. Please report the total number of ambulatory patients by age grouping.

	Age of Patient					
	Ages 0-14	Ages 15-64	Ages 65-74	Ages 75-85	Ages 85 and Up	Total
Number of Ambulatory Patients						

3. Please report the total number of ambulatory patients by gender.

	Gender of Patient		
	Male	Female	Total
Number of Ambulatory Patients			

4. Please report the total number of ambulatory patients by payment source. Report Peachcare for Kids as Third-Party.

	Payment Source			
	Medicare	Medicaid	Third-Party	Self-Pay
Number of Ambulatory Patients				

AHQ Perinatal Services Addendum

for 1/1/2006-12/31/2006

UID:

Georgia Department of Community Health

Facility UID

Facility Name

Level of Care:

Year:

Part A: Obstetrical Services Utilization

Please report the following obstetrical services information for the report period. Include all deliveries and births in any unit of the hospital or anywhere on its grounds.

1. **Number of Delivery Rooms**	
2. **Number of Birthing Rooms**	
3. **Number of LDR Rooms**	
4. **Number of LDRP Rooms**	
5. **Number of Cesarean Sections**	
6. **Total Live Births**	
7. **Total Births (Live and Late Fetal Deaths)**	
8. **Total Deliveries (Births + Early Fetal Deaths and Induced Terminations)**	

Part B: Newborn and Neonatal Nursery Services

Please report the following newborn and neonatal nursery information for the report period.

Type of Nursery	Set-Up and Staffed Beds/Station	Neonatal Admissions	Inpatient Days	Transfers within Hosp
1. Normal Newborn (Basic)				
2. Specialty Care - Intermediate Neonatal Care				
3. Subspecialty Care - Intensive Neonatal Care				
Totals				

Part C: Obstetrical Charges and Utilization by Mother's Race/Ethnicity and Age

1. Please provide the number of admissions and inpatient days for mothers by the mother's race using race/ethnicity classifications.

	Total Obstetrical Admissions by Race/Ethnicity							
	American Indian/ Alaska Native	Asian	Black/ African American	Hispanic or Latino	Hawaiian/ Pacific Islander	White	Multi-Racial	Total
Admissions by Mother's Race								
Inpatient Days								

Part C: Obstetrical Charges and Utilization by Mother's Race/Ethnicity and Age (cont.)

2. Please provide the number of admissions (mothers) by the following age groupings. All patient counts must balance.

	Age of Patient			
	Ages 0-14	**Ages 15-44**	**Ages 45 and Up**	**Total**
Number of Admissions				
Inpatient Days				

3. Please report the average hospital charge for an uncomplicated delivery (CPT 59400).

4. Please report the average hospital charge for a premature delivery.

AHQ Psychiatric and Substance Abuse Services Addendum for 1/1/2006-12/31/2006

UID:

Facility UID

Facility Name

Georgia Department of Community Health

Part A: Psychiatric and Substance Abuse Data by Program

Year:

1. Please report the number of beds as of the last day of the report period. Report beds only for officially recognized programs. For combined bed programs, please report each of the combined bed programs and the number of combined beds.

	General Acute Psychiatric			Acute Substance Abuse		Extended Care		
	A	B	C	D	E	F	G	H
	Adults 18 and over	Adolescents 13-17	Children 12 and under	Adults 18 and over	Adolescents 13-17	Adults 18 and over	Adolescents 13-17	Adolescents 0-12
Distribution of CON-Authorized Beds								
Set-Up and Staffed Beds								

	Combined Categories	
	Combined Programs (Indicate the Combined Programs Using Letters A Through G, for Example, "AB")	Number of Combined Beds
Distribution of CON- Authorized Beds		
Set-Up and Staffed Beds		

2. Please report the following utilization for the report period. Report only for officially recognized programs.

	General Acute Psychiatric			Acute Substance Abuse		Extended Care		
	A	B	C	D	E	F	G	H
	Adults 18 and over	Adolescents 13-17	Children 12 and under	Adults 18 and over	Adolescents 13-17	Adults 18 and over	Adolescents 13-17	Adolescents 0-12
Admissions								
Inpatient Days								
Discharges								
Discharge Days								
Average Charge Per Patient Day								
Check if this Program is JCAHO Accredited?	☐	☐	☐	☐	☐	☐	☐	☐

Part B: Psychiatric and Substance Abuse Utilization by Race/Ethnicity, Gender, and Payment Source

1. Please provide the number of admissions and inpatient days by the following race/ethnicity classifications.

	American Indian/ Alaska Native	Asian	Black/ African American	Hispanic or Latino	Hawaiian/ Pacific Islander	White	Multi-Racial	Total
Admissions								
Inpatient Days								

2. Please provide the number of admissions and inpatient days by the following gender classifications.

	Gender of Patient		Total
	Male	Female	
Admissions			
Inpatient Days			

3. Please indicate the number of patients by the following payment sources. Please note that individuals may have multiple payment sources. Report Peachcare for Kids as Third-Party.

	Payment Source			
	Medicare	Medicaid	Third-Party	Self-Pay
Number of Patients				
Inpatient Days				

LTCH Addendum

for 1/1/2006-12/31/2006

UID:

Georgia Department of Community Health

Facility UID

Facility Name

Year:

Part A: General Information

1. Check the box to the right if your Long Term Care Hospital is accredited? ☐

   1a. If you answered yes to question 1, please specify the the agency that accredits your facility in the space below.

   1b. Please provide you organization's level /status of accreditation.

2. **Number of Licensed LTCH beds**
3. **Permit Effective Date**
4. **Permit Designation**
5. **Number of CON beds**
6. **Number of SUS beds**
7. **Total Patient Days**
8. **Total Discharges**
9. **Total LTCH Admissions**

Part B: Utilization by Race, Age, Gender, and Payment Source

1. Please provide the number of admissions and inpatient days by race using the following race/ethnicity classifications.

	Total LTCH Days and Admissions by Race/Ethnicity							
	American Indian/ Alaska Native	**Asian**	**Black/ African American**	**Hispanic or Latino**	**Hawaiian/ Pacific Islander**	**White**	**Multi-Racial**	**Total**
Admissions								
Inpatient Days								

2. Please provide the number of admissions and inpatient days by the following age groupings.

	Age of LTCH Patient				
	Ages 0-65	**Ages 65-74**	**Ages 75-84**	**Ages 85 and Up**	**Total**
Admissions					
Inpatient Days					

3. Please provide the number of admissions and inpatient days by the following gender classifications.

	Gender of Patient		
	Male	**Female**	**Total**
Admissions			
Inpatient Days			

4. Please indicate the number of patients by the following payment sources. Please note that individuals may have multiple payment sources.

	Payment Source			
	Medicare	**Third-Party**	**Self-Pay**	**Other**
Number of Patients				
Inpatient Days				

Annual Hospital Questionnaire

Signature Form **for 1/1/2006-12/31/2006**

UID:

Georgia Department of Community Health

YOU MUST CHECK FOR ERRORS BEFORE COMPLETING THE SIGNATURE SECTION

In order to ensure the Signature Form will accept an authorized signature you must first click the "View Error Messages" button. This button will produce a report detailing any missing data items that are required or balances that do not agree but are required to be in balance. The Signature Form WILL NOT accept an authorized signature until each item on the Data Validation Report is corrected. After correcting errors, please click the "View Error Messages" button again to make sure that all errors have been cleared.

Electronic Signature

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Exective Officer or Executive Director (principal officer) of the facility. The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or inaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Authorized Signature: Date:

Title:

Comments:

Unresolved Data Issues

Please explain any unresolved data issues in the comments box.

#Error

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